STARS

Sports Therapy and Rehabilitation Services
Post-Surgical Questionnaire

PLEASE ANSWER THESE QUESTIONS IF YOU ARE HERE DUE TO RECENT SURGERY.

Name: _____ Date: _____

Date of Surgery: ___/___/____

Type of Surgery: _____

Have you had previous therapy for this issue? ☐Yes ☐No

If yes, please give dates, length of therapy, and setting in which treatment took place:

Hospital _____

Outpatient Clinic _____

Home Health _____

Please describe your symptoms prior to surgery: _____

_____

How did your symptoms begin prior to surgery? _____

_____

Please describe your symptoms since surgery: _____

_____

Since your surgery, would you report that your symptoms are: ☐ Better ☐ Worse ☐ Same

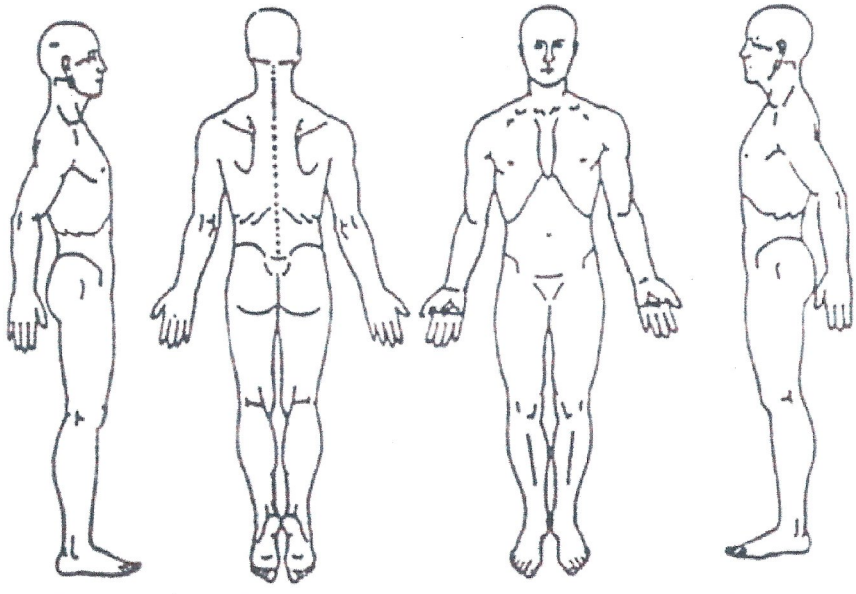
What functional limitations did you have before surgery? _____

_____

How often are your symptoms experienced since surgery?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Never

Please indicate location and intensity of pain on figures:



Right Back Front Left

Please indicate your pain level today based on the pain scale below:

No Pain Unbearable

0 1 2 3 4 5 6 7 8 9 10

Pain level with medication: _____ Pain level without medication: _____

Pain level during activity: _____ Pain level while at rest: _____